STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	05/05/2011

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PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN47720

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F0000	This visit was for Investigation of Complaints IN00089994, IN00089836, IN00089626, and IN00089748. This visit resulted in a partially extended survey - immediate jeopardy. Complaint IN00089994 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00089836 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, and F226. Complaint IN00089626 - Substantiated. Federal/state deficiencies related to the allegations are cited at F314. Complaint IN00089748 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, and F226.	F0000	By submittng tthe enclosed matterial we are nott admittng tthe ttrutth or accuracy ofl any speciflc flndings or allegattons. We reserve tthe rightt tto conttestt tthe flndings or allegattons as partt ofl any proceedings and submitt tthese responses pursuantt tto our regulattory obligattons The flacilitty requestts tthatt tthe plan ofl correctton be considered our allegatton ofl compliance eflecttve June 4, 2011 tto tthe complaintt survey conductted on May 5, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Unrelated deficiencies are cited. Survey date: 5/2/11 Extended survey dates: 5/3, 5/4, and 5/5/11 Facility number: 000442 Provider number: 155621 AIM number: 100266510 Survey team: Jennie Bartelt, RN, TC (5/2, 5/4, and 5/5/11) Diane Hancock, RN (5/2 and 5/3/11) Anne Marie Crays, RN (5/4 and 5/5/11) Census bed type: SNF: 43 SNF/F: 62 Total: 105 Census payor type: Medicare: 27 Medicaid: 46 Other: 32 Total: 105			

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	Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 10, 2011 by Bev Faulkner, RN			
F0223 SS=J	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure the resident was free from physical and verbal abuse for 1 of 4 residents reviewed related to allegations of abuse in a sample of 8. (Resident F) Resident F was physically and verbally abused by the visiting spouse. The facility failed to plan and/or implement interventions to protect the resident from further	F0223	**It is the practice of this facility to assure that its residents are free from any type of abuse, including both physical and verbal abuse, and that any instances are reported to the appropriate agencies as identified per the regulation** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident #F is free from any form of abuse, both physical and verbal, related to the spouse. The system identified in the abatement plan has been followed, allowing the spouse only	06/04/2011

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	abuse, and the visiting spouse repeated the verbal abuse. The reporting process for the second occurrence of abuse was not followed, and the facility failed to immediately plan and implement interventions to prevent further abuse. The deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 5/2/11 and began on 4/23/11. The Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Worker were notified of the Immediate Jeopardy on 5/2/11. The Immediate Jeopardy was removed on 5/4/11, but the facility remained out of compliance at the level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because the facility continued to inservice staff on abuse policies and procedures. Findings include:		supervised visits. ***Other residents that have the potential to be affected have been identified by:*** There have been no other residents identified related to any type of abusive situation. However, potentially all residents could be affected and the facility policy has been re-inserviced to assure a thorough understanding of the regulation related to abuse prevention and reporting immediately to the Administrator and appropriate authorities if an abusive situation was to occur. ***The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:*** The policy related to preventing and reporting of abuse in any form has been re-inserviced to assure a thorough understanding of the regulation including the prevention of abuse and the proper reporting of abuse in accordance with the guidelines for reporting of unusual occurrences in a timely manner. All staff has been in-serviced related to the policy. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to review the proper following of the abuse policy including prevention of abuse and the notification of	

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	During Initial Tour of the facility on 5/2/11 at 4:30 a.m., from the hallway through the open door, a man in street clothes was observed seated in an easy chair in (room of Resident F). The light next to the chair was on, and the man was holding a book in his hands. During interview on 5/2/11 at 6:05 a.m., LPN #2 and CNA #3 who were on night shift duty on Resident F's hall, indicated the Resident F's husband is up all night, every night in the resident's room. They indicated that sometimes the husband catnaps in the chair. They indicated someone is with Resident F 24 hours a day. They indicated during the daytime, a hired sitter is with the resident, not to provide care but to alert the staff to the need for care. At this time, the resident's open door was knocked upon, and no response was received. Stepping into the room, the resident was observed lying quietly in bed on her left side. The man in the chair was observed to have his eyes		the Administrator and appropriate state agencies. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any allegations in a timely manner. The Administrator, or designee, will complete this audit monthly x3, then quarterly x3. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** June 4, 2011	

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	closed, and his respirations were easy. Resident F's clinical record was reviewed on 5/2/11 at 6:25 a.m. The record indicated the resident was admitted to the facility on 4/16/11 following placement of a gastrostomy feeding tube. A Care Conference Note, dated 4/27/11, indicated in the section for Social Services, "Interview w/ [with] [name of Resident F's husband] regarding incident on 4/23/11. See Social Service Notes for more details." Social Service Progress Notes for 4/26/11 indicated, "Was notified of an incident that occurred over the weekend with resident & her husband. Staff reported husband grabbed her by the hair and shook her. Staff was assisting the resident with cleaning up. The husband thought she was being combative. He stated he had Ativan he could give her. He was told all meds			

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	[medications] needed to go through the facility & be ordered by a physician. Spoke to the son [name of son] - he had prepared statement from his father. '[Name of husband] would like for us to hear both sides of the story. He feels we have rec'd [received] bad information. He feels the report being made would be false as it is currently written. We would be well-advised to listen to what he has to say before making the final report.' [Name of son] would not discuss any history of aggression or abuse with his father. He stated he would not discuss it over the phone. He also stated he would not likely discuss his parents at the meeting, but would be there for moral support. Supervised visitation has been put into place and a visit log has been placed in the resident room to ensure when someone is in the room with the resident. A mtg [meeting] has been scheduled with [name of husband and son] tomorrow at 2:00 p.m."			

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	Social Service Progress Notes for 4/27/11 at 2:00 p.m. indicated, "Social Services [name of SW #2], Administrator [name of Interim Administrator], Nursing [name of Compliance Nurse, LPN #3] met with [name of Resident F's husband] and son, [name of son]. [Name of Resident F's husband] wanted to express his side of the story regarding the incident that occurred on 4/23/11. He admits his wife was upset & angry with the nurses for needing to change her. He admits he did grab her hair, but did not pull it and did not shake her head. He stated he did it because after 63 years of marriage he knows she does not like her hair being pulled. He states he would never give his wife his medication and understands all medicine must go through the physician and the facility. [Name of Resident F's husband] denies any wrong doing and states the staff is just out to get him. [Name of Interim Administrator], myself, and [Name of LPN #3] then spoke to [name of			

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	CNA #6] about the incident. She had given a written statement as to what happened. She states [name of Resident F's husband] grabbed her [Resident F] by the hair and shook her head. She states she did ask him to stop and told him that she had the situation under control. [Name of CNA #6] states she then reported it to the nurse on duty. A report was sent to the state dept [department] of health on 4/27/11." During interview on 5/2/11 at 6:15 a.m., LPN #2 indicated Resident F's son was in the resident's room with the resident and Resident F's husband until about 2:15 a.m. that morning, when the son indicated to LPN #2 he was going home to get some sleep. LPN #2 indicated the family was very concerned about the resident's care. LPN #2 indicated Resident F's husband does not assist with the resident's care - only staff provides care, but the husband calls for assistance as needed.			

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	During interview on 5/2/11 at 6:30 a.m., in regard to the Care Conference Note, dated 4/27/11, LPN #2 indicated he did not know anything about an incident with Resident F's husband. During interview on 5/2/11 at 7:05 a.m., CNA #3 was observed providing care on Resident F's hall. During interview at this time, CNA #3 indicated she wasn't aware of Resident F's husband ever being mean to Resident F. CNA #3 also indicated she usually worked upstairs [on the facility's second floor] but was providing the care on Resident F's hall at this time. Review of the facility's binder containing files of incidents reported to the Indiana State Department of Health included, but was not limited to, a report titled, "Facility Incident Reporting Form," for "Incident Date: 4/23/11 Incident Time: 6:15 a.m." Attached to the report was copy of a handwritten statement, dated			

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	4/23/11. The statement indicated, "I [name of CNA #6] entered the room of [name of Resident F] to change her and get her dressed. She was wet, she was digging at her bottom with her nails keeping herself raw & soar [sic]. I was holding her hands so she would not dig at herself. [Resident F's] husband kept saying to [name of Resident F] let go of her. I explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat and grabbed [name of Resident F] by the hair of the head and began shaking her head by the hair of her head yelling let go of her. He made the statement that he had Adavan [sic] [Ativan - antianxiety medication] in his pocket & that he would give her some. I explained that no he could not do that." Also attached to the Facility Incident Reporting Form was copy of an e-mail, dated 4/25/11 at 12:43 p.m., sent from [name of LPN #4]			

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	to LPN #3. The e-mail indicated, "On April 23, 2011, my two aides were discussing the care of a resident with me. One stated that the husband had tried to pull her hair while they were taking her to the bathroom. Aide made the commit [sic] that the husband was being mean to the wife. The second aide reported that he was not being mean to her he was trying to keep her from being combative while they were taking her to the bathroom. I was the nurse on the unit at the time and did not see or hear this take place. I was in the residence [sic] room frequently that shift and did not observe the husband being mean to his wife. He did report that she needed something to keep her calm at which point I called the on call physician and got orders for PRN [as needed] Ativan 1 mg along with a urinalysis. She was placed on acute charting at that time for the Ativan order." The Facility Incident Reporting			

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	Form indicated the following: In the section for Brief Description of Incident: "[Name of CNA #6] was providing patient care for resident following an incontinent episode with husband in room....According to husband during interview on April 27th around 2:00 p.m., husband states that he did grab his wife's hair but denied pulling or shaking of wife's head. Husband also denied offering his wife any medication, but does admit to carrying his own medication with him during his visits." In the section for Preventive Measures Taken: "Resident was monitored throughout weekend and acute charting was initiated following the placement of a new order for prn Ativan. Recommended supervised visits. As of Monday April 25th, a personal sitter had been hired by family to sit at bedside to assist with care. A visitor log has been			

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	placed in the resident's room to be filled out by visitor or sitter. No further incidents of physical abuse have been noted. Nurse will be educated on facility policy regarding timely reporting of incidents of alleged abuse before next scheduled shift." On 5/2/11 at 8:20 a.m., two men were observed leaving the facility. One of the men was using a walker. During interview at this time, LPN #5 indicated the two men were Resident F's husband and son. LPN #5 indicated Resident F's son had come to the facility to pick up Resident F's husband, and a sitter was now in the room with Resident F. LPN #5 also indicated that was an "odd situation" in regard to Resident F's family. When asked to explain, LPN #5 indicated she didn't know what to say about it and "like you say, it's an odd situation." Interview with Social Worker (SW) #2 was completed on 5/2/11 at 8:35			

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	a.m. SW #2 had come to the Conference Room where clinical records were being reviewed to locate the clinical record for Resident F. SW #2 indicated she wanted to put her note from Friday [4/29/11] about an incident with Resident F's husband into the clinical record. SW #2 indicated Resident F's husband had not been physically abusive but had called the resident names. SW #2 indicated [name of Resident F's husband] won't talk on the phone, because he is hard of hearing. She indicated he was in the military and that you "can tell he wants things done a certain way and expects it." SW #2 indicated Resident F had excoriation to her periarea, which is painful for her. SW #2 indicated she had contacted the local Ombudsman to brainstorm about possible ideas to manage the resident, so the resident's husband will be managed. SW #2 indicated the son doesn't want to intervene as best she can tell. SW #2 indicated the family has kept the resident at			

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	home until she had the G-tube placed before admission. SW #2 indicated as far as she could tell, the resident had not had much change in care needs except for the G-tube care. SW #2 indicated she didn't want to tell the resident's husband not to come in to visit. She indicated the problems between the resident and her husband had occurred during care in the morning. She indicated Resident F's husband has usually left the building before she arrives. SW #2 indicated she planned to give Resident F's husband and son information about resident abuse. In her hand SW #2 had a list of ideas on a red piece of paper, which she indicated were the ideas she and the Ombudsman discussed, and an envelope addressed with the names of Resident F's husband and son. The Social Service Progress Notes, dated 4/29/11 at 8:00 a.m., indicated, "Social Services was notified at 7:45 a.m. that another			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN47720

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	incident had occurred with [name of Resident F's husband]. When I went to the resident room to address the incident [name of Resident F's husband] had already been picked up by his son, [name of Resident F's son]. The sitter, [name of sitter] was still in the room. I questioned her about the happenings in the room. She states the CNAs were providing pericare because she had an incontinent episode. [Name of resident F] was combative because of the pain and confusion. She states, '[Name of resident F's husband] said stop acting like a 4 yr [year] old & told her to shut up.' She states he did not get physical with his wife. I then questioned CNA [name of CNA #6]. She states [Name of Resident F's husband] doesn't understand that [name of Resident F] is in a lot of pain from how raw she is and is not trying to fight them in spite. She states he said, 'Shut up, [name of Resident F], Shut up [name of Resident F] - quit acting like a 4 yr old.' He also said, 'You			

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	can't talk to someone without a brain.' [Name of Resident F] then whispered to [name of CNA #6], 'Make him stop, make him stop!' [Name of CNA #6] states as she and other aid [sic] were leaving the room he went to the bedside & tried to tell resident that the staff was not trying to hurt her. I then questioned [name of CNA #4], the other CNA. She states he did tell her to shut up and yelled at her. She states this is not the first time. She states he has been verbally abusive with his wife and with staff in the past. She is not sure of the exact verbiage. I did try to contact [name of Resident F's son], but was unable to do so." Notes on 4/29/11 at 2:00 p.m., indicated SW #2 spoke with the Assistant Director of Nursing about the resident's "being so raw and uncomfortable." Notes on 4/29/11 at 2:30 p.m., indicated SW #2 spoke with the Ombudsman about the "ideas on plan of care. Will leave resident rights on abuse for [names of Resident F's husband and son]."			

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	During observation on 5/2/11 at 9:15 a.m., a young lady in street clothes was seated in the easy chair in Resident F's room. During interview at this time, she indicated she was the resident's private sitter and would be in the room today from 7:00 a.m. to 7:00 p.m. She also indicated she was employed by the facility as a housekeeper and would not be providing resident care. LPN #5 entered the room and indicated she would be providing the resident's water flush to the gastrostomy tube. Observed on a small table beside the easy chair was a list labeled in handwriting, "All Visitors Must Sign In" and a notebook with dates and handwritten notations. LPN #5 indicated she thought the visitor list was placed there by social services, and the sitter indicated the notebook belonged to the family and contained notes on the resident's care. During interview on 5/2/11 at 9:50			

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	a.m. in regard to her report of family to resident physical abuse on 4/23/11, CNA #6 described the hair pulling and grasped the hair on the top of her own head and demonstrated a side to side jerking motion. CNA #6 indicated that almost every time she goes into the room, when the resident is combative, her husband yells at her. She indicated the resident says "Get him out of here." She indicated she is holding the resident's hands so she won't dig at herself. During observation of personal care for Resident F by CNAs #6 and #4 on 5/2/11 at 10:30 a.m., the resident was observed to repeatedly reach to the buttock and groin area, call out "Oh that hurts," and grab at the CNAs' hands during care. The buttocks near the anal area were observed to have small bright red areas and open an area on the tailbone. The resident calmed and closed her eyes when the care was completed.			

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	During interview with CNA #4 on 5/2/11 at 11:00 a.m., she reiterated her report as recorded in the Social Services Progress Notes for 4/29/11 at 8:00 a.m. CNA #4 indicated she had seen the sign in paper in the Resident F's room, but that no one had said to have people coming into the room to sign in on it. CNA #4 indicated, "That's his [Resident F's husband's] paper, I think." During interview on 5/2/11 at 2:15 p.m., the Interim Administrator and Compliance Nurse, LPN #3, indicated the incident of verbal abuse of Resident F by Resident F's husband on 4/29/11 had not been reported to them. An Immediate Jeopardy was identified on 5/2/11. The Immediate Jeopardy began on 4/23/11 when a visiting spouse physically and verbally abused his wife. The Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Worker were notified on 5/2/11 at 3:50 p.m.			

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	of the Immediate Jeopardy related to the failure to prevent physical and verbal abuse and implement policies related to prevention, investigation, protecting, and reporting abuse. The Immediate Jeopardy was removed on 5/4/11 at 4:00 p.m., when through observations, interviews, and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy, and that the steps taken removed the immediacy of the problem. Review of policy and procedure, observations of staff and visitor interaction with residents, and staff interview related to inservicing on the facility's policy and procedure related to abuse, indicated staff was knowledgeable of what and to whom to report. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal			

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	harm that is not Immediate Jeopardy. This federal tag is related to Complaints IN00089836 and IN00089748. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=J	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure allegations of abuse were reported timely to the Administrator	F0225	**Itt is tthe practtce ofi tthis fiacilitty tto assure tthatt any fiorm ofi abuse is reportted tto tthe Administtrattor and tto tthe appropriatte agencies as identtfied per tthe regulatton**	06/04/2011

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	and State agency, and failed to thoroughly investigate and protect the resident during investigation for 1 of 4 residents reviewed related to abuse in a sample of 8. (Resident F) Resident F was physically and verbally abused by the visiting spouse and verbally abused by the spouse on a second occasion. The deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 5/2/11 and began on 4/23/11. The Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Worker were notified of the Immediate Jeopardy on 5/2/11. The Immediate Jeopardy was removed on 5/4/11, but the facility remained out of compliance at the level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because the facility continued to inservice staff on abuse policies and procedures.		***The correctve acton taken fior those residents fiound to be afiected by the deficient practce include :*** There have been no flurtther abusive incidentts bettwee#F and her spouse. ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be aflectted and tthe policy has been re-inserviced tto assure a tthorough understtanding ofl tthe regulatton There have been no allegattons or observattons ofl incidentts ofl abuse witth any otther residentts ***The measures or systemic changes that have been put into place to ensure that the deficient practce does not recur include:*** The policy relatted tto reporttng ofl any ttype ofl abuse has been re-inserviced tto assure a tthorough understtanding ofl tthe regulatton including tthe reporttng ofl abuse tto tthe flacilitty Administtrattor and ofl unusual occurrences in a ttmely manner tto otther appropriatte agencies as required by tthe regulatton. All sttafl has been in-serviced relatted tto tthe policy ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto review tthe proper	

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	Findings include: Resident F's clinical record was reviewed on 5/2/11 at 6:25 a.m. The record indicated the resident was admitted to the facility on 4/16/11 following placement of a gastrostomy feeding tube. A Care Conference Note, dated 4/27/11, indicated in the section for Social Services, "Interview w/ [with] [name of Resident F's husband] regarding incident on 4/23/11. See Social Service Notes for more details." Social Service Progress Notes for 4/26/11 indicated, "Was notified of an incident that occurred over the weekend with resident & her husband. Staff reported husband grabbed her by the hair and shook her. Staff was assisting the resident with cleaning up. The husband thought she was being combative. He stated he had Ativan he could give her. He was told all meds [medications] needed to go through		flollowing ofl tthe abuse policy including nottflcatton ofl tthe appropriatte sttatte agencies. It is tthe Administtrattor's responsibilitty tto assure tthatt tthe appropriatte agencies are nottfled ofl any allegattons in a ttmely manner. The Administtrattor or designee, will complette tthis auditt montthly x3, tthen quartterly x1. The Quality Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** June 4, 2011	

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	the facility & be ordered by a physician...." Review of facility binder containing files of incidents reported to the Indiana State Department of Health included, but was not limited to, a report titled, "Facility Incident Reporting Form," for "Incident Date: 4/23/11 Incident Time: 6:15 a.m." Attached to the report was copy of a handwritten statement, dated 4/23/11. The statement indicated, "I [name of CNA #6] entered the room of [name of Resident F] to change her and get her dressed. She was wet, she was digging at her bottom with her nails keeping herself raw & soar [sic]. I was holding her hands so she would not dig at herself. [Resident F's] husband kept saying to [name of Resident F] let go of her. I explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat and grabbed [name of Resident F]			

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	by the hair of the head and began shaking her head by the hair of her head yelling let go of her. He made the statement that he had Adavan [sic] [Ativan - antianxiety medication] in his pocket & that he would give her some. I explained that no he could not do that." Also attached to the Facility Incident Reporting Form was copy of an e-mail, dated 4/25/11 at 12:43 p.m., sent from [name of LPN #4] to LPN #3. The e-mail indicated, "On April 23, 2011, my two aides were discussing the care of a resident with me. One stated that the husband had tried to pull her hair while they were taking her to the bathroom. Aide made the commit [sic] that the husband was being mean to the wife. The second aide reported that he was not being mean to her he was trying to keep her from being combative while they were taking her to the bathroom. I was the nurse on the unit at the time and did not see or hear this take place. I was in the			

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	residence [sic] room frequently that shift and did not observe the husband being mean to his wife. He did report that she needed something to keep her calm at which point I called the on call physician and got orders for PRN [as needed] Ativan 1 mg along with a urinalysis. She was placed on acute charting at that time for the Ativan order." The Facility Incident Reporting Form, in the section for Preventive Measures Taken, indicated, "Resident was monitored throughout weekend and acute charting was initiated following the placement of a new order for prn Ativan. Recommended supervised visits. As of Monday April 25th, a personal sitter had been hired by family to sit at bedside to assist with care. A visitor log has been placed in the resident's room to be filled out by visitor or sitter. No further incidents of physical abuse have been noted. Nurse will be educated on facility policy			

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regarding timely reporting of incidents of alleged abuse before next scheduled shift."

A handwritten notation on the Facility Incident Reporting Form" indicated, "E-mailed to [name if Indiana State Department of Health employee] 4/27/11; 4/27/11 Faxed 5:10 by [name of Interim Administrator] to include statements 4 pages total."

Interview with Social Worker (SW) #2 was completed on 5/2/11 at 8:35 a.m. SW #2 had come to the Conference Room where clinical records were being reviewed to locate the clinical record for Resident F. SW #2 indicated she wanted to put her note from Friday [4/29/11] about an incident with Resident F's husband into the clinical record. SW #2 indicated Resident F's husband had not been physically abusive but had called the resident names.

The Social Service Progress Notes,

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	dated 4/29/11 at 8:00 a.m., indicated, "Social Services was notified at 7:45 a.m. that another incident had occurred with [name of Resident F's husband]. When I went to the resident room to address the incident [name of Resident F's husband] had already been picked up by his son, [name of Resident F's son]. The sitter, [name of sitter] was still in the room. I questioned her about the happenings in the room. She states the CNAs were providing pericare because she had an incontinent episode. [Name of resident F] was combative because of the pain and confusion. She states, '[Name of resident F's husband] said stop acting like a 4 yr [year] old & told her to shut up.' She states he did not get physical with his wife. I then questioned CNA [name of CNA #6]. She states [Name of Resident F's husband] doesn't understand that [name of Resident F] is in a lot of pain from how raw she is and is not trying to fight them in spite. She states he said, 'Shut			

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	up, [name of Resident F], Shut up [name of Resident F] - quit acting like a 4 yr old.' He also said, 'You can't talk to someone without a brain.' [Name of Resident F] then whispered to [name of CNA #6], 'Make him stop, make him stop!' [Name of CNA #6] states as she and other aid [sic] were leaving the room he went to the bedside & tried to tell resident that the staff was not trying to hurt her. I then questioned [name of CNA #4], the other CNA. She states he did tell her to shut up and yelled at her. She states this is not the first time. She states he has been verbally abusive with his wife and with staff in the past. She is not sure of the exact verbiage. I did try to contact [name of Resident F's son], but as unable to do so." Notes on 4/29/11 at 2:00 p.m., indicated SW #2 spoke with the Assistant Director of Nursing about the resident's "being so raw and uncomfortable." Notes on 4/29/11 at 2:30 p.m., indicated SW #2 spoke with the Ombudsman about the "ideas on plan of care. Will			

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	leave resident rights on abuse for [names of Resident F's husband and son]." During interview on 5/2/11 at 2:15 p.m., the Interim Administrator and Compliance Nurse, LPN #3, indicated the incident of verbal abuse of Resident F by Resident F's husband on 4/29/11 had not been reported to them. The Interim Administrator indicated the facility's protocol for reporting allegations of abuse had not been followed. An Immediate Jeopardy was identified on 5/2/11. The Immediate Jeopardy began on 4/23/11 when a visiting spouse physically and verbally abused his wife. The Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Worker were notified on 5/2/11 at 3:50 p.m. of the Immediate Jeopardy related to the failure to report, protect, and investigate an allegation of physical and verbal abuse The Immediate			

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	Jeopardy was removed on 5/4/11 at 4:00 p.m., when through observations, interviews, and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy, and that the steps taken removed the immediacy of the problem. Review of policy and procedure, observations of staff and visitor interaction with residents, and staff interview related to inservicing on the facility's policy and procedure related to abuse, indicated staff was knowledgeable of what and to whom to report. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. This federal tag is related to Complaints IN00089836 and			

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	IN00089748. 3.1-28(c) 3.1-28(d)			
F0226 SS=J	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure its policy was followed related to timely reporting of allegations of abuse to the Administrator and State agency, and thoroughly investigating and protecting the resident during investigation for 1 of 4 residents reviewed related to abuse in a sample of 8. (Resident F) Resident F was physically and verbally abused by the visiting	F0226	**Itt is tthe practtce ofi tthis fiacilitty tto assure tthatt tthe Administtrattor is nottfied immediattely relatted tto any allegatton ofi abusę neglectt, or misappropriatton ofi propertty The Administtrattor is tthen responsible fior nottfiying tthe appropriatte agencies as required in a ttmely manner per tthe fiacilitty policy and tthe regulatton** ***The correctve acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentt#F has had no flurtther incidentts relatted tto tthe occurrence ofl abuse. Please refler tto systtemic changes relatted tto tthe policy and	06/04/2011

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	spouse, the allegation was not reported timely, and the resident was not protected from further abuse. A second allegation of abuse was not reported timely for investigation and protection of the resident. The deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 5/2/11 and began on 4/23/11. The Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Worker were notified of the Immediate Jeopardy on 5/2/11. The Immediate Jeopardy was removed on 5/4/11, but the facility remained out of compliance at the level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because the facility continued to inservice staff on abuse policies and procedures. Findings include: The facility's policy entitled "Abuse		reporttng mechanisms tto tthe Administtrattor and tthe appropriatte sttatte agencies ***Other residents that have the potental to be afiected have been identfied by :*** There have been no incidentts ofl abuse relatted tto any addittonal residentts. Pottenttally all residentts could be aflectted and tthereflore tthe currentt policy has been reinserviced tto assure a tthorough understtanding ofl tthe regulatton ***The measures or systemic changes that have been put into place to ensure that the deficient practce does not recur include:*** The policy relatted tto tthe preventton and tthe reporttng ofl any florm ofl abuse has been re-inserviced tto assure a tthorough understtanding ofl tthe regulatton including tthe immediatte nottflcatton ofl tthe Administtrattor and tthe reporttng ofl unusual occurrences in a ttmely manner. All sttafl has been in-serviced relatted tto tthe policy ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto review reporttable eventts tto assure tthatt tthey are reportted ttmely in accordance witth tthe flacilitty policy and tthe regulatton.Itt is tthe Administtrattor's responsibilitty tto assure tthatt tthe appropriatte agencies	

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	Prohibition" was requested and was provided on 5/2/11 at 11:00 a.m. on the Conference Room table.. Review of the policy indicated, "Policy: Allegations/suspicions/reports of abuse will be investigated immediately to ensure the safety and well being of the resident." The Procedure sections included, but were not limited to, "Any team member with knowledge of an alleged abuse incident will report it immediately to the unit/charge nurse, supervisor, nursing administration, DON [Director of Nursing], or Administrator....Nursing administration, DON, or Administrator will submit a written report to the appropriate state and local agencies...." The Prevention section included, but was not limited to, "Reported instances of any of the above situations will be investigated immediately and reported to the appropriate authorities and agencies....Review the situation and assess some of the		are nottfled ofl any allegattons in a ttmely manner. The Administtrattor or designee, will complette tthis auditt montthly x8, tthen quartterly x3. The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** June 4, 2011	

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	following options: ...Is staff monitoring of the situation adequate to keep the resident from further harm? Is it necessary to consider contacting Adult Protective Services if a family member or guardian is involved? ...Witness statement should be documented as soon after the incident as possible. Nursing administration, DON, or Administrator will be notified immediately of any alleged incident so the investigative process can begin and precautionary measure taken to protect the resident from further problems." Resident F's clinical record was reviewed on 5/2/11 at 6:25 a.m. The record indicated the resident was admitted to the facility on 4/16/11 following placement of a gastrostomy feeding tube. A Care Conference Note, dated 4/27/11, indicated in the section for Social Services, "Interview w/ [with] [name of Resident F's			

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	husband] regarding incident on 4/23/11. See Social Service Notes for more details." Social Service Progress Notes for 4/26/11 indicated, "Was notified of an incident that occurred over the weekend with resident & her husband. Staff reported husband grabbed her by the hair and shook her. Staff was assisting the resident with cleaning up. The husband thought she was being combative. He stated he had Ativan he could give her. He was told all meds [medications] needed to go through the facility & be ordered by a physician...." Review of facility binder containing files of incidents reported to the Indiana State Department of Health included, but was not limited to, a report titled, "Facility Incident Reporting Form," for "Incident Date: 4/23/11 Incident Time: 6:15 a.m." Attached to the report was copy of a handwritten statement, dated			

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	4/23/11. The statement indicated, "I [name of CNA #6] entered the room of [name of Resident F] to change her and get her dressed. She was wet, she was digging at her bottom with her nails keeping herself raw & soar [sic]. I was holding her hands so she would not dig at herself. [Resident F's] husband kept saying to [name of Resident F] let go of her. I explained to him that I was the one holding her hands so that she didn't scratch herself. [Name of Resident F's husband] got up from his seat and grabbed [name of Resident F] by the hair of the head and began shaking her head by the hair of her head yelling let go of her. He made the statement that he had Adavan [sic] [Ativan - antianxiety medication] in his pocket & that he would give her some. I explained that no he could not do that." Also attached to the Facility Incident Reporting Form was copy of an e-mail, dated 4/25/11 at 12:43 p.m., sent from [name of LPN #4]			

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	to LPN #3. The e-mail indicated, "On April 23, 2011, my two aides were discussing the care of a resident with me. One stated that the husband had tried to pull her hair while they were taking her to the bathroom. Aide made the commit [sic] that the husband was being mean to the wife. The second aide reported that he was not being mean to her he was trying to keep her from being combative while they were taking her to the bathroom. I was the nurse on the unit at the time and did not see or hear this take place. I was in the residence [sic] room frequently that shift and did not observe the husband being mean to his wife. He did report that she needed something to keep her calm at which point I called the on call physician and got orders for PRN [as needed] Ativan 1 mg along with a urinalysis. She was placed on acute charting at that time for the Ativan order." The Facility Incident Reporting			

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	Form, in the section for Preventive Measures Taken, indicated, "Resident was monitored throughout weekend and acute charting was initiated following the placement of a new order for prn Ativan. Recommended supervised visits. As of Monday April 25th, a personal sitter had been hired by family to sit at bedside to assist with care. A visitor log has been placed in the resident's room to be filled out by visitor or sitter. No further incidents of physical abuse have been noted. Nurse will be educated on facility policy regarding timely reporting of incidents of alleged abuse before next scheduled shift." A handwritten notation on the Facility Incident Reporting Form" indicated, "E-mailed to [name if Indiana State Department of Health employee] 4/27/11; 4/27/11 Faxed 5:10 by [name of Interim Administrator] to include statements 4 pages total."			

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	Interview with Social Worker (SW) #2 was completed on 5/2/11 at 8:35 a.m. SW #2 had come to the Conference Room where clinical records were being reviewed to locate the clinical record for Resident F. SW #2 indicated she wanted to put her note from Friday [4/29/11] about an incident with Resident F's husband into the clinical record. SW #2 indicated Resident F's husband had not been physically abusive but had called the resident names. The Social Service Progress Notes, dated 4/29/11 at 8:00 a.m., indicated, "Social Services was notified at 7:45 a.m. that another incident had occurred with [name of Resident F's husband]. When I went to the resident room to address the incident [name of Resident F's husband] had already been picked up by his son, [name of Resident F's son]. The sitter, [name of sitter] was still in the room. I questioned her about the happenings in the room. She states			

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	the CNAs were providing pericare because she had an incontinent episode. [Name of resident F] was combative because of the pain and confusion. She states, '[Name of resident F's husband] said stop acting like a 4 yr [year] old & told her to shut up.' She states he did not get physical with his wife. I then questioned CNA [name of CNA #6]. She states [Name of Resident F's husband] doesn't understand that [name of Resident F] is in a lot of pain from how raw she is and is not trying to fight them in spite. She states he said, 'Shut up, [name of Resident F], Shut up [name of Resident F] - quit acting like a 4 yr old.' He also said, 'You can't talk to someone without a brain.' [Name of Resident F] then whispered to [name of CNA #6], 'Make him stop, make him stop!' [Name of CNA #6] states as she and other aid [sic] were leaving the room he went to the bedside & tried to tell resident that the staff was not trying to hurt her. I then questioned [name of CNA #4], the other CNA.			

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	She states he did tell her to shut up and yelled at her. She states this is not the first time. She states he has been verbally abusive with his wife and with staff in the past. She is not sure of the exact verbiage. I did try to contact [name of Resident F's son], but as unable to do so." Notes on 4/29/11 at 2:00 p.m., indicated SW #2 spoke with the Assistant Director of Nursing about the resident's "being so raw and uncomfortable." Notes on 4/29/11 at 2:30 p.m., indicated SW #2 spoke with the Ombudsman about the "ideas on plan of care. Will leave resident rights on abuse for [names of Resident F's husband and son]." During interview on 5/2/11 at 2:15 p.m., the Interim Administrator and Compliance Nurse, LPN #3, indicated the incident of verbal abuse of Resident F by Resident F's husband on 4/29/11 had not been reported to them. The Interim Administrator indicated the facility's protocol for reporting			

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	allegations of abuse had not been followed. An Immediate Jeopardy was identified on 5/2/11. The Immediate Jeopardy began on 4/23/11 when a visiting spouse physically and verbally abused his wife. The Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Worker were notified on 5/2/11 at 3:50 p.m., of the Immediate Jeopardy related to the failure to follow policies related to reporting, protecting residents, and investigating an allegation of physical and verbal abuse. The Immediate Jeopardy was removed on 5/4/11 at 4:00 p.m., when through observations, interviews, and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy, and that the steps taken removed the immediacy of the problem. Review of policy and procedure, observations of staff and visitor			

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	interaction with residents, and staff interview related to inservicing on the facility's policy and procedure related to abuse\ indicated staff was knowledgeable of what and to whom to report. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. This federal tag is related to Complaints IN00089836 and IN00089748. 3.1-28(c) 3.1-28(d)			

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F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure care was provided to 2 of 8 sampled residents, in a manner to maintain or enhance their dignity, in that staff were observed to barge into bathrooms and/or resident rooms without knocking and waiting to be asked in, and care needs were discussed from hallway into a resident's room. (Residents H and I) Findings include: 1. On 5/2/11 at 11:25 a.m., CNA #8 was observed to open the common bathroom door, without knocking or announcing herself, and enter the bathroom. She had verbalized in the hallway, prior to entering, that she was looking for her glasses. At 11:31 a.m., Resident H was observed coming out of the bathroom in her wheelchair. She	F0241	**Itt is tthe practtce ofi tthis fiacilitty tto assure tthatt tthe all residentts receive care and services in a manner and environmentt tthatt mainttains or enhances each residentt's dignitty** ***The correctve acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentts#H and #I are botth receiving care and services in a manner tthatt mainttains ttheir dignitty ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be aflectted Thereflore, please see below flor systtemic changes relatted tto enhancing residentts' dignitty ***The measures or systemic changes that have been put into place to ensure that the deficient practce does not recur include:*** All sttafl has been in-serviced relatted tto tthe provision ofl enhancing residentts' dignitty The in-service is inclusive ofl tthe need tto knock on residentts' doors prior tto enttering and assuring tthatt any conversattons which are relatted tto residentts are conductted in a privatte manner conducive tto residentts' confldenttalitty and dignitty ***The correctve acton taken to monitor perfiormance to assure compliance through quality***	06/04/2011

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	155621	A. BUILDING 00 B. WING	05/05/2011

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	indicated, "Another thing, there's no privacy in the bathroom! They never knock, just come in and out while I'm in there." 2. During interview on 5/2/11 at 1:15 p.m., Resident I indicated her legs were hurting. As the room was exited, LPN #8 was observed at the medication cart in the hallway outside Resident I's room. The information about the resident's legs was passed along to LPN #8. LPN #8 called loudly from the hallway into Resident #8's room, "[Name of Resident #8], you want some Tylenol?" 3.1-31(t)		***assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto observe flor tthe provision ofl dignitty, onfldenttalitty The Directtor ofl Nursingor designee, will complette tthis auditt weekly 3x montthly x8, tthen quartterly 3x. Any issue identtfled will be immediattely correctted The Quality Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** June 4, 2011	

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to ensure the resident's pain was thoroughly assessed, care planned and interventions implemented to manage pain for 2 of 3 residents reviewed related to pain in a sample of 8. (Residents E and F) Findings include: 1. During observation on 5/2/11 at 10:30 a.m., CNA #4 and CNA #6 were observed providing incontinent care for Resident F. As the perineal and buttocks areas were cleansed, the resident cried out, "Oh, that hurts - it's hurting." CNA #4 indicated the resident's buttocks area had been more red	F0309	**Itt is tthe practtce ofi tthis fiacilitty tto assure tthatt tthe all residentts receive tthe necessary care and services tto attain or mainttain tthe highestt practtcable physical, mentta) and psychosocial well-being, in accordance witth tthe comprehensive assessmentt** ***The correctve acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentts#E and #F have had updatted pain assessmentts and have intterventtons in place tto address any discomflortt ***Other residents that have the potental to be afiected have been identfied by :*** All residentts have been reviewed tto assure tthatt all residentts tthatt experience pain are having ttheir needs addressed appropriattely ***The measures or systemic changes that have been put into place to ensure that the deficient practce does not recur include:*** Nurses have been in-serviced relatted tto assuring tthatt residentts who experience pain are ttreatted	06/04/2011

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	and bleeding on Friday (4/29/11), and she told the nurse. Small bright red areas were observed near the anal area, and an open pinkish-yellow open area was observed on the coccyx. The resident stated, "I'm going down here - it hurts" and reached toward the perianal area. CNA #4 and #6 indicated the resident always complained of pain when she was wet and when incontinence care was provided, and they indicated they often had the resident hold the hands of one CNA so the other could provide care as the resident would be combative during incontinence care. Immediately after the observation, the nurse, LPN #5 was asked to assess the open area to the coccyx as soon as possible. During interview on 5/2/11 at 12:40 p.m., LPN #5 indicated she had assessed the resident's wound as the therapists were assisting the resident back to bed. She indicated the wound was a Stage 2 pressure		appropriattely The in-service was inclusive ofl nott only tthe occurrence ofl physical pain, butt ofl also ttreattng pain prior tto procedures, ifl possible, ifl a residentt is known tto experience pain during tthe provision ofl care ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto observe flor tthe provision ofl appropriatte pain managementt The ttool will randomly review5 residentts tto assure tthatt all residentts witth identtfled pain have appropriatte intterventtons in place The Directtor ofl Nursingor designee, will complette tthis auditt weekly3x montthly x8, tthen quartterly x8. Any issue identtfled will be immediattely correctted The Quality Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** June 4, 2011	

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	ulcer right on the tailbone. Documentation of the wound description was requested at this time, and LPN #5 provided a form entitled, "Skin Ulcer Documentation," dated 5/2/11, which indicated Resident F had a Stage 2 pressure ulcer measuring 0.8 X 0.9 cm with less than 0.1 cm depth. The documentation indicated the nurse was unable to assess the resident's pain. The clinical record for Resident F was reviewed on 5/2/11 at 6:25 a.m. The Minimum Data Set assessment, signed as completed 4/29/11 by the RN Coordinator, indicated the following in the Care Area Assessment signed by SW#2, the Social Services Director: "...She has severe dementia and currently has a feeding tube. She is alert at times, but not oriented. She is very confused and anxious. She has numerous episodes of incontinence. She has become very raw and infected in her vaginal and anal			

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	area causing her pain during these episodes and also during pericare. She is at times combative with staff at this time, but it is painful and she is confused....She is able to express her pain...." Documentation on the undated "Pain Assessment" form, located in the section of the clinical record with admission assessments, indicated with a check mark, "No pain." No other documentation was indicated on the form. Daily Medicare Charting notes for 4/29/11 at 11:00 a.m., indicated, "Res. [resident] resting in bed quietly. Upon T & R [turn and reposition] et [and] incont care, res. noted to have min [minimum] -moderate hemorrhoidal bleeding et buttocks very excoriated. She has superficial scratching/excoriation along both side of rectum but [symbol for no] drainage et area is superficial. MD notified of this....Res. has [symbol for no] pain except when incont [incontinent]			

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	care is given [symbol for after] loose BMs [bowel movements] et she gets her rectum washed. Preparation H [hemorrhoid medication] applied per order along [symbol for with] Magic Butt Cream." A physician's admission order for Tylenol 325 mg, two every 6 hours was changed on 4/20/11 to, "Administer Tylenol 1000 mg. q [every] 6 [symbol for hours] per peg [gastrostomy] tube. Dx [diagnosis]: pain." Documentation failed to indicate further physician's orders related to pain management, including as needed pain medications, through 5/4/11. Social Service Progress Notes, dated 4/29/11 at 2:00 p.m., indicated, "Spoke to ADON [Assistant Director of Nursing] about [name of Resident F] being so raw and uncomfortable to see if anything else can be done." Documentation failed to indicate			

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	further assessment or care planning related to the resident's pain during care. On 5/4/11 at 5:50 p.m., Resident F was observed seated in her wheel chair in the hallway looking out the window. The resident's son was standing next to her. The son was overheard indicating her bottom was hurting and asking for a pillow. The Director of Nursing also heard the request and indicated she would obtain a pillow for the resident. On 5/5/11 at 2:15 p.m., Occupational Therapist #1 and Physical Therapist #1 were observed assisting Resident F to ambulate in the hall. When the resident became tired, the therapists assisted the resident to be seated in her wheel chair. The resident moaned and grimaced as she was seated. During interview at this time, the therapists indicated they were uncertain about her pain. On 5/5/11 at 1:30 P.M., the Director of Nursing [DON]			

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	provided the current facility policy on "Pain Management," undated. The policy included, "It is the policy of this facility to respect and support the resident' s right to optimal pain management ...It is the responsibility of all nursing staff to assess and periodically reassess the resident for pain and relief from pain ...Nursing shall also observed for pain indicators: facial expression ...vocalizations ...body movements ...." 2. On 5/4/11 at 12:30 P.M., PT [Physical Therapist] #1 and OT (Occupational Therapist) #1 were observed transferring Resident E to bed. The resident was moaning out, and a family member at the bedside indicated, "His backside is hurting." The resident was observed to be grimacing and moaning while being repositioned in bed. LPN # 6 then entered the room to remove the resident's dressing off of his coccyx area. The resident was observed to be moaning during the dressing			

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	change. A pressure sore was observed on the coccyx. LPN # 6 indicated the dressing was changed daily and as needed. LPN # 6 indicated at that time that the resident could have Tylenol or Lortab if needed. LPN # 6 indicated the resident "will usually ask for it." LPN # 6 then asked the resident if his back was hurting, and indicated to him, "It's probably that arthritis." Resident E indicated he was hurting, but did not specify where. The clinical record of Resident E was again reviewed on 5/5/11 at 12:30 P.M. Diagnoses included, but were not limited to, cancer of tongue, respiratory failure, pneumonia, and acute renal failure. A Physician's order, initially dated 2/23/11 and on the current April 2011 orders, indicated, "Lortab [pain medication] ...every 4 hours as needed for pain." An additional Physician's order, initially dated 2/28/11 and on the current April			

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	2011 orders, indicated, "APAP ...2 tabs ...every 4 hours prn [as needed] pain ...." A Minimum Data Set [MDS] assessment, dated 4/21/11, indicated the resident was totally dependent on two or more staff for bed mobility and transfer, and was not on a scheduled pain medication regimen or received prn [as needed] pain medications, in the past 5 days, A Care Plan, dated 4/20/11, indicated a problem of "Pain, generalized, Resident may be experiencing pain AEB [as evidenced by] Crying, moaning, Related to: Cancer." Interventions included, "Monitor for non-verbal indicators of pain such as: facial grimacing, moaning ...Update Pain Assessments as needed. Encourage not to wait too long to ask for pain medication as it will take it longer to take effect ...." A Pain Assessment, dated 4/27/11,			

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	indicated, "Does resident verbalize symptoms of pain ...Generalized aches/pains ...Facial expressions, Frowning/scowling, Wrinkled brow, Moaning ...Medical condition, Cancer, Hx [history] OA [osteoarthritis], Pain is relieved by Medication ...Resident experienced no pain or discomfort during the assessment period. Does have occas. c/o's [complaints of] generalized discomfort during the past month looking back." A Medication Administration Record [MAR], dated May 2011, indicated Resident E did not receive Lortab for the month of May. The MAR indicated the resident received "APAP" on 5/4/11 at 1:00 P.M. for "c/o back pain." A MAR, dated April 2011, indicated the resident received Lortab once, on 4/9/11. The MAR indicated the resident received Tylenol, or APAP, three times, on 4/8, 4/11, and 4/23/11.			

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	3.1-37(a)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure care was planned and implemented for prevention and care for pressure ulcers for 2 of 4 residents reviewed related to pressure ulcers in a sample of 8. (Residents E and F)	F0314	**Itt is tthe practtce ofi tthis fiacilitty tto assure tthatt all residentts receive tthe necessary care and services tto preventt and ttreatt pressure ulcers** ***The correctve acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentts#E and #F have been reviewed tto assure tthatt appropriatte	06/04/2011

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	Findings include: 1. During observation on 5/2/11 at 4:45 a.m., Resident E was observed lying on his back in bed on a specialty air mattress. CNA #7 was at the bedside preparing to empty the resident's Foley catheter bag. During interview at this time, CNA #7 indicated the resident had a pressure wound to his back, which had been debrided recently, and pressure ulcers to his heels. The clinical record fro Resident E was reviewed on 5/2/11 at 7:45 a.m. The record indicated the resident was admitted to the facility on 2/12/11, discharged to the hospital on 3/10/11, and readmitted to the facility on 3/24/11. The Pressure Ulcer Risk Assessment, dated 2/12/11, indicated the resident had a high risk of pressure ulcer, with a score of 9. The assessment form indicated a score of 8 or above represented high risk. Subsequent Pressure Ulcer Risk Assessments on 2/19 and 2/26/11 indicated high risk with scores of 8 on both dates. The Pressure Ulcer Risk Assessment for 3/5/11 indicated a score of 7. The Nursing Admission Assessment, dated 2/12/11, indicated, "Bottom - red"		measures are in place tto preventt and/or ttreatt pressure ulcers ***Other residents that have the potental to be afiected have been identfied by :*** All residentts tthatt currenttly have pressure ulcers have been reviewed tto assure tthatt proper ttreattmentts and services are in place tto assistt with tthe healing ofl wounds All residentts have been reviewed Those residentts identtfled as high risk flor pressure ulcers have been reviewed tto assure tthatt tthere are preventtve measures in place tto assistt witth tthe preventton ofl pressure ulcer developmentt ***The measures or systemic changes that have been put into place to ensure that the deficient practce does not recur include:*** Nursing sttafl has been in-serviced relatted tto tthe preventton and/or ttreattmentt ofl pressure ulcers. The in-service included nott only tthe acttual ttreattmentt and assessmentt ofl pressure ulcers, butt also identtflying tthose residentts tthatt eitther have a pressure ulcer or are att high risk ofl pressure ulcers tto assure tthatt appropriatte intterventtons are in place tto promotte healing and/or tto preventt tthe developmentt ofl pressure ulcers. The nurses have also been in-serviced relatted tto flollowing tthe policy relatted tto providing ttreattmentts in accordance witth tthe accepttable guidelines ofl inflectton conttrol	

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	in the section for Skin Problems. Physician's orders, dated 2/14/11, indicated to apply Magic Butt Cream to the buttocks every shift and as needed. During interview on 5/2/11 at 7:00 a.m., LPN #6, Unit Manager for Resident E's nursing unit, indicated the schedule for a resident's weekly skin checks are on the Medication Administration Record. She indicated if the resident has a new skin problem, forms for describing and tracking the wounds are started. Nurse's notes, dated 3/8/11, at 10:00 a.m., indicated, "...Deep red colored area noted to the (lt) [left] side of coccyx. 3 cm X 4 cm. Skin is intact. Call placed to Dr. [name of physician]. Message left for return call. Res. [resident] to be turned lt. to rt. [right] while in bed." A Weekly Nondecubitus Report, dated 3/8/11, indicated, "Description: Dark red/purple area 3 cm X 4 cm. Skin intact. Bruise-like in appearance." A physician's order, dated 3/8/11, indicated, "Apply skin prep to bilateral heels q [every] shift; float heels" and "Skin prep area on coccyx q shift." A physician's order, dated 3/9/11, indicated, "Multipodus boots while in		***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto observe flor tthe provision ofl wound care, assessmentt ofl pressure ulcers, and tto assure tthatt preventtve measures are in place tto preventt tthe developmentt ofl pressure ulcers. The ttool will randomly review 5 residentts tto assure tthatt proper intterventtons are in place relatted tto tthe preventtons and/or ttreattmentt ofl pressure ulcers The Directtor ofl Nursingor designee, will complette tthis auditt weekly x3, montthly x3, tthen quartterly x3. Any issue identtfled will be immediattely correctted The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** June 4, 2011	

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	bed." Documentation in Nurse's Notes and wound sheets failed to indicate an assessment of the resident's heels. A Nurse's Note for 3/9/11 at 2:00 p.m., indicated, "Skin remains intact over areas to heels et [and] coccyx...N/O's [new orders] rec'd [received] per Dr. [name of physician] for wound protocol et Multipodus boots bil [bilateral] feet while in bed. Turned rt/lt only. [Arrow pointing up] in w/c [wheel chair] for short periods of time...." A Nurse's Note for 3/10/11 at 6:50 p.m., indicated the nurse was called to the room by the resident's spouse. The resident was having difficulty breathing, and bright red blood was suctioned from the mouth. The resident was sent to the hospital. A hospital note from the Wound Ostomy Continence Nurse, dated 3/11/11 at 12:58 p.m., indicated, "Here per consult...wife at bedside, she reported to this RN that areas at heels have only been there a couple of days, but buttock area has been a couple of weeks. Assessment of bilateral heels reveals two areas of pressure, closed blood blister, is DTI (deep tissue injury). Areas are currently closed, soft.... L [left] heel wound measures over all 3.5 X 4.5			

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	cm with an intact blood blister within this area that measures approximately 3 X 2.5 cm, R [right] heel wound measure overall 3.5 X 4 cm with an intact blood blister within this area that measures approximately 0.5 X 0.2, this area will most likely need no topical treatment if TEDs [thromboembolytic deterrent stockings] are not reapplied. Bilateral buttock has a scattered red, raised rash with satellite lesions that is yeast. Within area of yeast at coccyx there is an area of pressure located just R of the gluteal cleft on R buttock that measure approximately 1.8 X 3 cm, this is dark, thick, adherent eschar, peri-wound skin is blanchable but yeast covered....After yeast is resolved, will need a change in treatment orders to heal large area of eschar at coccyx.... A hospital note from the Wound Ostomy Continence Nurse, dated 3/24/11 at 10:28 a.m. indicated, "WOCN here per nurse request to reassess wounds prior to patient discharge....Skin assessment reveals a wound to the coccyx that measure approximately 2 X 4 cm. Within the wound bed is an area of eschar that measures approximately 1 X 1.5 cm. The remaining wound bed is covered by thin yellow slough. The edges are open, and peri-wound skin is intact. The skin within the gluteal cleft and extending out toward the bilateral buttock and coccyx still has			

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red maculopapular rash with satellite lesions extending from the rash. This appears to be yeast. Although it appears to be improving, the rash has not resolved. For these reasons treatment cannot be changed. The right heel wound now measure approximately 3.2 X 5 cm. The area is an intact fluid filled blister. At the left heel is a wound that measure approximately 2.3 X 1.2 cm. This is an area of intact eschar. Discussed wound care with primary RN. When yeast resolves a Duoderm would be appropriate to provide autolytic debridement to the coccyx wound...."

The Pressure Ulcer Risk Assessment, dated 3/24/11, indicated the resident was high risk for pressure ulcers, with a score of 8 with 8 or above representing high risk.

A physician's order, dated 3/24/11, indicated, "Apply Magic Butt to buttocks BID [two times daily]."

The Care Plan, dated 3/25/11, with "Problem: At risk for pressure ulcer" had the goal: "Will not develop any pressure ulcers." Interventions indicated by check mark indicated, "Assess/record changes in skin status, Report pertinent changes in skin status to MD, Monitor lab results as ordered and report abnormal results to

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	physician, Turn and reposition every two hours, Specialty bed/mattress, Chair cushion, Provide incontinence care after each incontinent episode, Avoid skin to skin contact, Minimize pressure over bony prominences." The Pressure Ulcer Risk Assessment, dated 3/31/11, indicated the resident was high risk for pressure ulcers with a total score of 14. Documentation failed to indicate the care plan was updated related to the increased risk. The Pressure Ulcer Risk Assessments, dated 4/7 and 4/14/11, indicated the resident continued to be a high risk for pressure ulcers with a total score of 13 on each assessment. Documentation failed to indicate the care plan was updated related to the increased risk. A. The Skin Ulcer Documentation form,, dated 3/24/11, indicated a wound to the coccyx: "Date: 3/24/11; Stage: 2; Length X Width: 8 X 5 [cm]; Depth: 0.5 [cm]; Location & extent of any tunneling or sinus tract: N/A [not applicable]; Exudate: N/A; Pain: 0; Color: Red & black; Tissue type: Granulation; Describe			

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	Edges and Surrounding Tissue: Red; When physician notified/saw: 3/24/11." The Skin Ulcer Documentation form, dated 3/31/11 and 4/1/11 indicated a wound to the sacrum, "Stage: 2; Length X Width: 6 X 4.1; Depth: 0.5; [no tunneling, exudate, or pain]; Color: Pink; Tissue Type: granulation; Describe Edges and Surrounding Tissue: Red. The next assessment of the wound was dated 4/18/11 and was described as a wound to the sacrum. Documentation indicated: Stage: Eschar; Length X Width: 3.1 X 4.6; Depth: 0.2; Location & extent of any tunneling or sinus tract: None; Exudate: Purulent; Pain: 3; Color: Yellow Slough; Tissue Type: Eschar Middle; Describe Edges & Surrounding Tissue: Thin wound margin; When physician notified/saw: Seen by [name of wound consultant] this date." The next assessment of the wound was dated 4/25/11. The space for the wound stage was blank. "Length X Width: 3.2 X 4.7; Depth: 0.6; Location & extent of any tunneling or sinus tract: None; Exudate: Purulent; Pain: 3; Color: Yellow slough; Describe Edges & Surrounding Tissue: Distinct attached; When physician notified/saw: Measurement per wound specialist."			

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During interview on 5/2/11 at 1:15 p.m. related to the care of the resident's coccyx wound upon return from the hospital on 3/24/11, LPN #6, Unit Manager for Resident E's hall, indicated until 4/18/11, when the wound consultant began seeing Resident E, the resident's wound had been red and dried, and only Magic Butt Cream had been ordered for care. LPN #6 indicated the wound consultant began providing care when the edges around the eschar began to lift and drainage developed.

Nurse's Notes for 4/18/11 at 6:00 p.m. indicated, "Wound Care Consultant [name] @ facility, progress note written, n.o. [new order] received....See t/o [telephone order] this date."

Nurse's Notes for 4/18/11 at 6:45 p.m. indicated, "[Name of provider] updated on n.o. for air mattress. Awaiting delivery of mattress this eve as ordered."

Nurse's Notes for 4/18/11 at 8:00 p.m. indicated, "Air mattress delivered & placed on bed as ordered."

The wound consultant's note for 4/18/11 indicated the pressure ulcer to the sacrum was an unstageable pressure wound to the sacrum measuring 3.1 X 4.6 X 0.2 (length

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	X width X depth) described as, "Decubitus ulcer on sacrum has yellow slough [symbol for with] 60% eschar and thin wound margins the is unstageable at this time." The plan included to discontinue the current treatment to the sacral wound and obtain an alternating pressure air mattress. A physician's order, dated 4/18/11, indicated, "Rinse sacral wound [symbol for with] wound cleanser, apply Santyl oint [ointment], cover [symbol for with] Aquacel Ag, dry gauze, secure [symbol for with] Telfa island, [symbol for change] QD [every day] and PRN [as needed] soiling." The wound consultant's note for 4/25/11 indicated the resident's sacral wound was debrided with a sharp scalpel to 3.0 cm X 4.7 cm X 1.4 cm granulating base. The wound consultant's note for 5/2/11 indicated the sacral wound was 3.5 X 4.3 X 1.2 at a Stage III. The assessment indicated, "Decubitus ulcer on sacrum has 100% yellow slough [symbol for with] tunneling, w/o [without odor]." On 5/4/11 at 12:40 P.M., PT [Physical Therapist] # 1 and OT [Occupational Therapist] # 1 were observed transferring Resident E to bed. The resident ' s coccyx			

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	area was then observed. LPN # 6 removed the dressing, which had a moderate amount of tannish drainage. LPN # 6 indicated the wound doctor was looking at the wounds, and she thought it had been staged as a Stage IV. The wound was observed to have a yellowish wound bed, and to have depth and tunneling. B. The Skin Ulcer Documentation form, dated 3/24/11, 3/31/11, and 4/1/11, for a pressure ulcer to the left heel indicated the resident had a 10 X 8 cm Stage II with no depth, tunneling, or exudate. The Color was described as "brown blister," "skin is brown," and "skin brown & intact." The Tissue Type was described as: "blister," "closed blister," and "closed blister." The Edges and Surrounding Skin were described as "blister" each week. The Skin Ulcer Documentation form, dated 4/8/11 indicated a 10 X 8 brown closed blister with description of Edges and Surrounding Tissue as "Fluid filled blister." The Skin Ulcer Documentation form, dated 4/15/11, was blank. Physician's orders, dated 3/24/11, indicated, "...Float heels, apply Betadine BID [two times daily] to bilateral heels."			

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	A physician's order, dated 3/28/11, indicated, "Multi-podus boot to lt [left] foot when in bed" with "Indication - Dx [diagnosis] blister to Lt heel." The wound consultant's note, dated 4/18/11, indicated the resident's left heel pressure wound was a deep tissue injury 2.8 X 3.4 X < 0.1, which was 100% black. C. The Skin Ulcer Documentation form, dated 3/24/11, 3/31/11, 4/1/11, and 4/8/11, for a pressure ulcer to the right heel indicated the resident had a 4 X 2 cm Stage II with no depth, tunneling, or exudate. The Color was described as "Red/brown." The Tissue Type was described as: "Closed." The Edges and Surrounding Skin were described as "Red" each week. The Skin Ulcer Documentation form, dated 4/15/11, was blank. The wound consultant's note, dated 4/18/11, indicated the resident's right heel pressure wound was an unstageable deep tissue injury 2.5 X 1.2 X < 0.1. The plan for both of the heel ulcers was the use of multipodus boots and skin prep to the heels. On 5/4/11 at 12:40 P.M., PT # 1 and OT #			

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	1 were observed transferring Resident E to bed. A family member indicated, "Oh, there's blood on his sock." A bloody spot was observed on the resident's sock. PT # 1 indicated at that time that, "We know. We were going to tell the nurse, that eschar [scab] came off of his left heel." A skin assessment was requested at that time. PT #1 then lifted the resident's left heel, and an open area was observed, approximately the size of a quarter, with a small amount of bleeding noted. The right heel was observed to have a darkened area, skin intact. PT #1 then replaced both of the multi-podus boots to each leg. LPN # 6 then entered the room and indicated, "Therapy saved the eschar for me," and displayed the scab-like area in a glove. On 5/5/11 at 12:10 P.M., the clinical record of Resident E was again reviewed. Documentation was lacking regarding the left heel eschar coming off of the resident's left heel. A physician's order for a different treatment for the heel was lacking. LPN # 6 was interviewed at that time regarding the treatment for Resident E's heel. LPN #6 indicated, "He gets the multi-podus boots." LPN # 6 indicated she had not observed the resident's left heel since the eschar had come off, and had not notified the physician of that fact. LPN #6 indicated she would contact the			

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	physician immediately, and obtain treatment orders. On 5/5/11 at 1:00 P.M., LPN # 6 indicated she had contacted the physician, and he ordered Bacitracin [antibiotic cream] twice daily, then to cover with Telfa and a Kling dressing. LPN # 6 indicated she also received an order to wrap the right heel with a Kling dressing. LPN # 6 indicated the physician "wanted to know how the scab had come off, and I told him I didn't know." During interview on 5/5/11 at 11:25 a.m., the Director of Nursing indicated documentation seemed to be missing from the clinical records. During interview on 5/5/11 at 1:40 p.m., the Director of Nursing indicated she understood the concern related to pressure ulcers. She indicated she had just started her job at the facility on 5/2/11, and she was uncertain if the resident's wound had not actually been assessed, or assessed inaccurately because the nurse needed education about wounds and wound care. 2. The clinical record for Resident F was reviewed on 5/2/11 at 6:25 a.m. The record indicated the resident was admitted on 4/16/11 following placement of a gastrostomy tube.			

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The Pressure Ulcer Risk Assessment, dated 4/16/11 indicated the resident had a high risk for pressure ulcers.

The admission Minimum Data Set assessment, dated 4/23/11, indicated the resident had , one Stage 1 pressure ulcer (intact skin with non-blanchable redness or a localized area usually over a bony prominence).

The Medication Administration Record was signed with a nurse's initials indicating the resident's skin was assessed by the nurse on 4/16, 4/23, and 4/30/11.

The Skin Ulcer Documentation Sheet for April 2011 indicated the following for pressure ulcers on the buttocks: On 4/16/11, the resident had one Stage 1 ulcer, 7 X 6 cm with no depth and red in color. On 4/23/11, the resident had one Stage 1 ulcer, with "excoriation" written in the column for length X width. No documentation was indicated to describe the ulcer on 4/30/11.

A physician's order for 4/25/11 indicated, "Apply Magic Butt Cream to groin/buttock q [every] shift et [and] [symbol for after] incont [incontinent] episodes."

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	Daily Medicare Charting notes for 4/29/11 at 11:00 a.m. indicated, "Res. [resident] resting in bed quietly. Upon T & R [turn and reposition] et [and] incont care, res. noted to have min [minimum] -moderate hemorrhoidal bleeding et buttocks very excoriated. She has superficial scratching/excoriation along both side of rectum but [symbol for no] drainage et area is superficial. MD notified of this....Res. has [symbol for no] pain except when incont [incontinent] care is given [symbol for after] loose BMs [bowel movements] et she gets her rectum washed. Preparation H [hemorrhoid medication] applied per order along [symbol for with] Magic Butt Cream." During observation on 5/2/11 at 10:30 a.m., CNA #4 and CNA #6 were observed providing incontinent care for Resident F. As the perineal and buttocks areas were cleansed, the resident cried out, "Oh, that hurts - it's hurting." CNA #4 indicated the resident's buttocks area had been more red and bleeding on Friday (4/29/11), and she told the nurse. Small bright red areas were observed near the anal area, and an open pinkish-yellow open area was observed on the coccyx. The resident stated, "I'm going down here - it hurts" and reached toward the perianal area. CNA #4 and #6 indicated the resident always complained of pain when she was			

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	wet and when incontinent care was provided, and they indicated they often had the resident hold the hands of one CNA so the other could provide care as the resident would be combative during incontinent care. Immediately after the observation, the nurse, LPN #5 was asked to assess the open area to the coccyx as soon as possible. During interview on 5/2/11 at 12:40 p.m., LPN #5 indicated she had already assessed the resident's wound, when the therapists were assisting the resident back to bed. She indicated the wound was a Stage 2 pressure ulcer right on the tailbone. Documentation of the wound description was requested at this time, and LPN #5 provided a form entitled, "Skin Ulcer Documentation," dated 5/2/11, which indicated Resident F had a Stage 2 pressure ulcer measuring 0.8 X 0.9 cm with less than 0.1 cm depth. The documentation indicated the nurse was unable to assess the resident's pain. Nurse's Notes for 5/2/11 at 11:00 a.m. indicated, "...She cont. [continues] to have excoriation to buttocks from scratching et [and] is also noted to have St. [Stage 2] area to coccyx 0.8 X 0.9 depth is < [less than] 0.1 cm et OA [open area] is only inclusive of very top layer of skin. Area is red [symbol for without] exudate noted.			

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	155621	A. BUILDING 00 B. WING	05/05/2011

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	MD [physician] notified for treatment...." A physician's order, dated 5/2/11, indicated, "Apply Xenaderm to coccyx, cover [symbol for with] foam drsg [dressing], [symbol for change] daily & PRN [as needed]." The Care Plan, dated 4/18/11, was a preprinted form indicating the resident was at risk for pressure ulcers with check marks next to interventions for assessment of the skin, reporting changes to the physician, administering and monitoring of medications, providing feedings and monitoring dietary needs, turning and repositioning, providing and monitoring effectiveness of pressure relieving or reduction devices for bed and chair, providing incontinent care, avoiding skin to skin contact, and minimizing pressure over bony prominence. The Care Plan, dated 5/2/11, was a preprinted form indicating the resident had a Stage 2 pressure ulcer. The following additional interventions were added to the plan: "Monitor lab/diagnostics as ordered and report abnormal results to MD," "Administer/monitor effectiveness of response to treatment(s) as ordered," and "Monitor the need for and provide			

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	consultation as needed." This federal tag is related to Complaint #IN00089626. 3.1-40(a)(2)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure its infection control policies and procedures were	F0441	**Itt is tthe practtce ofi tthis fiacilitty tto assure tthatt all residentts receive tthe necessary care and services tto preventt and ttreatt pressure ulcers** ***The correctve acton taken fior***	06/04/2011

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	followed. The deficient practice affected 1 of 2 residents reviewed related to Foley catheter management in a sample of 8 (Resident E) and 1 of 2 residents observed during dressing change in a sample of 8 (Resident H). Findings include: 1. During observation on 5/4/11 at 1:30 p.m., RN #7 was observed providing wound care for Resident H. The nurse placed a package of Kerlix and a package of Coban on the floor next the resident's feet, and donned clean gloves. The resident provided a folded blanket for the nurse to sit on in front of the resident's wheel chair. RN#7 seated herself on the blanket and assisted the resident to raise the right pant leg. A wound was observed on the back of the right calf. No dressing was on the wound. The nurse opened a package containing a Prisma dressing, and placed the Prisma on the wound and covered it with a		***those residents fiound to be afiected by the deficient practce include :*** Residentt#E receives catthetter care in accordance witth tthe accepttable parametters ofl inflectton conttrol Residentt#H receives dressing changes in accordance witth tthe accepttable parametters ofl inflectton conttrol ***Other residents that have the potental to be afiected have been identfied by :*** All residentts tthatt currenttly have floley catthetters have been reviewed tto assure tthatt tthe catthetter is provided appropriattely in accordance witth inflectton conttrol guidelines. All residentts tthatt have identtfled ttreattmentts have been reviewed tto assure tthatt ttreattmentts are provided in a manner tthatt is witthin accepttable parametters ofl inflectton conttrol ***The measures or systemic changes that have been put into place to ensure that the deficient practce does not recur include:*** Nurses have been in-serviced relatted tto tthe provision ofl ttreattmentts appropriattely in accordance witth flacilitty policy and accepttable parametters ofl inflectton conttrol. The in-service included tthe procedure tto esttablish a clean surflace and proper hand washing and glove changes. All nursing sttafl and ttherapy sttafl have been in-serviced relatted tto appropriatte care tto be provided flor tthose residentts tthatt have floley	

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	gauze pad. The nurse picked up the package of Kerlix from the floor, opened it, and wrapped the leg with the dressing. The nurse then picked up the package of Coban, opened it, and wrapped the leg with the dressing. Without changing gloves and washing hands, the nurse removed the sock on the resident's left foot, and opened a package of skin prep, which she applied to a dark red raised area on the resident's second toe of the right foot. The clinical record for Resident H was reviewed on 5/2/11 at 2:00 p.m. Physician's orders for May 2011 included, but were not limited to, "Dress ulcers anterior rt [right] leg & posterior rt leg [symbol for with] Prisma matrix cut to wound size. Cover [symbol for with] dry 4 X 4 dsg [dressing] gauze, wrap [symbol for with] Kerlix & secure [symbol for with] Coban, [symbol for change] M-W-F [Monday -		catthetters. The in-service includes assuring tthatt tthe catthetter bag remains below tthe level ofl tthe bladder and tthatt itt should never be allowed tto ttouch tthe floor ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto monittor tthe provision ofl wound care and tto assure tthatt ttreattmentts are perflormed appropriattely. In additton, a separatte Perflormance Improvementt Tool will be uttlized tto observe inflectton conttrol flor tthose residentts tthatt have a floley catthetter. Botth ttools will randomly review 5 residentts (ifl applicable) tto assure tthatt services provided are in accordance witth inflectton conttrol guidelines. The Directtor ofl Nursing or designee, will complette tthis auditt weekly x3, montthly x3, tthen quartterly x3. Any issue identtfled will be immediattely corrected. The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** June 4, 2011	

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	Wednesday - Friday]." A physician's order, dated 5/2/11, indicated the dressing should be changed every other day. The facility's policy entitled "Dressing Application," dated 8/08, was provided by the Director of Nurses (DON) on 5/5/11 at 3:15 p.m. The policy included, but was not limited to, "Purpose: To prevent infection in an open area and prevent contaminated drainage from touching clothes or linen. Procedure...4. Make a barrier at the bedside with a towel or washcloth....11. Apply the clean dressing. 12. Remove your gloves...14. Wash your hands with soap and water...." 2. On 5/4/11 at 12:30 P.M., PT (Physical Therapist) # 1 and OT (Occupational Therapist) # 1 were observed transferring Resident E to bed. The Foley catheter bag was observed to be lying on the floor during the transfer, and during the positioning of the resident. On 5/5/11 at 12:10 P.M., a skin assessment was requested on Resident E.			

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	When entering the room, the Foley catheter bag was observed lying on the floor. LPN # 6 assessed both of the resident's heels, but she did not move the Foley catheter bag off of the floor. The clinical record of Resident E was reviewed again on 5/5/11 at 12:30 P.M. A physician's order, initial date unknown but on the April 2011 orders, indicated, " Foley Cath [catheter] ...d/t [due to] retention. " A Care Plan, dated 4/28/11, indicated a problem of "Urinary Catheter, At risk for developing complications due to catheter use ...." The Interventions included, but were not limited to, "Provide catheter care per policy ...." On 5/5/11 at 1:30 P.M., the Director of Nursing provided the current facility policy on "Foley Catheter Care," dated 8/08. The policy included, "...The purpose of catheter care if to prevent possible urinary tract infections ...The catheter and drainage bag should be kept as a closed system ...." The policy did not indicate how to position the Foley catheter drainage bag. On 5/5/11 at 1:30 P.M., during interview, the Director of Nursing indicated the catheter bag should not have been on the			

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	floor at any time. 3.1-18(b)(2) 3.1-18(l)			